### CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICA I - TO BE COM								: Z602 cility ID: 00498	
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245534  2.STATE VENDOR OR MEDICAID NO.     (L2)		3. NAME AND ADI (L3) CAPITOL VI (L4) 640 JACKSO (L5) SAINT PAUL	DRESS OF FACILITIEW TRANSITIO	Y	E CENTER	(L6) <b>551</b>		1. Initia 3. Tern 5. Valid	OF ACTION:	2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other	n
5. EFFECTIVE DATE CHANGE OF OWN (L9)		7. PROVIDER/SUP	05 HHA	09 ESRD	13 PTIP	(L7)	2 CLIA		Survey After Con		
6. DATE OF SURVEY 05/12/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIG	CE			EAR ENDING I	DATE: (L	35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12. Total Facility Beds 13. Total Certified Beds  14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 32 (L37) (L38)  16. STATE SURVEY AGENCY REMARKS	32 (L18) 32 (L17) 19 SNF (L39)	B. Not in Comp Requirements a ICF (L42)	nce With quirements Based On: cceptable POC pliance with Program and/or Applied Waive  IID  (L43)		2345. * Code:	Technical 24 Hour I 7-Day RN Life Safet  A*	Personnel RN N (Rural SNF) ty Code	_ 6. _ 7. _ 8.	quirements: Scope of Servic Medical Directe Patient Room Si Beds/Room  (L15)	es Limit or	
17. SURVEYOR SIGNATURE  Mary Heim, HPR Socia	al Work Spe	Date:	05/12/2016	(L19)			agency ar sTon, P		Specialis	Date: <u>t</u> 05/18/201	6 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE (	OR SING	GLE STAT	TE AGENC	Y		
DETERMINATION OF ELIGIBILITY	cipate (L21)		PLIANCE WITH CI ITS ACT:	VIL	21.	2. Owne			CFA-2572) ure Stmt (HCFA-	:1513)	
22. ORIGINAL DATE  OF PARTICIPATION  04/01/1989  (L24)	23. LTC AGREEMI BEGINNING (L41)		4. LTC AGREEMEN ENDING DATE (L25)		26. TERM  VOLUNTAL  01-Merger, 0  02-Dissatisfa	RY Closure	ACTION:  00  Reimburseme		INVOLUNTA	et Health/Safety	
25. LTC EXTENSION DATE:  (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Ir 04-Other Rea	-			OTHER 07-Provider S 00-Active	tatus Change	
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMAR	RKS					
	(L28)	03001		(L31)							

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)

31. RO RECEIPT OF CMS-1539



### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 18, 2016

Ms. Michelle Mangan, Administrator Capitol View Transitional Care Center 640 Jackson Street Saint Paul, Minnesota 55101

RE: Project Number S5534026

Dear Ms. Mangan:

On May 12, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

The Federal Form CMS-2567 is being electronically delivered.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Program Assurance Unit

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/18/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245534	B. WING _			05/	12/2016
	ROVIDER OR SUPPLIER	ARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 640 JACKSON STREET SAINT PAUL, MN 55101	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  Capitol View Transiti found to be in complic of 42 CFR Part 483,	onal Care Center has been ance with the requirements				ME.	
ABORATORY	DIRECTOR'S OR PROVIDED!	SUPPLIER REPRESENTATIVE'S SIGNATU	IRF	TITLE			(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

F5534026

Printed: 05/17/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A, BUILDING 02 - CAPITAL VIEW TRANSITIONAL

CARE UNIT

(X3) DATE SURVEY COMPLETED

245534

B. WING

05/12/2016

NAME OF PROVIDER OR SUPPLIER

CAPITOL VIEW TRANSITIONAL CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

640 JACKSON STREET SAINT PAUL, MN 55101

	S	AINT PAUL, MN	55101	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULA OR LSC IDENTIFYING INFORMATION)	ATORY PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		
	A Life Safety Code survey was conducted by Minnesota Department of Public Safety, State Fire Marshal Division on May 12, 2016, at the request of Minnesota Department of Health. At the time of this survey, Capitol View Transition Care Center, located on the 8th floor of Region Hospital, was found to be in substantial compliance with the requirements for participal in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC Chapter 18 New Health Care.	At nal ons ation		
	This 10-story building was constructed in 196 and was determined to be of Type I(332) construction. The building has a full basement and is fully fire sprinklered. The building has a alarm system, with smoke detection in spaces open to the corridor and in all resident rooms is monitored for automatic fire department notification. The facility has a capacity of 32 b and had a census of 29 beds at the time of the survey.	at a fire s , that	x	
	The requirement at 42 CFR, Subpart 483.70(MET.	a) is		
			9	
	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIV		TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted May 18, 2016

Ms. Michelle Mangan, Administrator Capitol View Transitional Care Center 640 Jackson Street Saint Paul, Minnesota 55101

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5534026

Dear Ms. Mangan:

The above facility was surveyed on May 9, 2016 through May 12, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

Capitol View Transitional Care Center May 18, 2016 Page 2

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

PRINTED: 05/18/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00498	B. WING		05/1	2/2016
	ROVIDER OR SUPPLIER	640 JACKS	RESS, CITY, STA SON STREET	TE, ZIP CODE		
CAPITOL	VIEW TRANSITIONAL CA	ARE CENTER	L, MN 55101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEN	TION*****				
	NH LICENSING CO	ORRECTION ORDER				
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of finithe Minnesota Depart.  Determination of whe corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessment of the runumber and MN Rule.	ther a violation has been				
	that may result from rorders provided that a the Department within notice of assessment INITIAL COMMENTS			Minnesota Department of Health is		
	this Department's star and the following corr When corrections are date, make a copy of original to the Minnes	ff, visited the above provider ection orders are issued. completed, please sign and these orders and return the ota Department of Health, be Monitoring, Licensing and		documenting the State Licensing Correction Orders using federal softw. Tag numbers have been assigned to Minnesota state statutes/rules for Nur Homes.		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION N		l ` ′	CONSTRUCTION	(X3) DATE SU COMPLE	
		00498		B. WING		05/1	2/2016
		00436				05/12	2/2010
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
CAPITOL	VIEW TRANSITIONAL CA	ARE CENTER		ON STREET L, MN 55101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENC Y MUST BE PRECEDED .SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	Continued From page	<del>:</del> 1		2 000			
	Certification Programs Minnesota 55164-090		, St. Paul,		The assigned tag number appears in the far left column entitled "ID Prefix Tag. The state statute/rule out of compliance listed in the "Summary Statement of Deficiencies" column and replaces the Comply" portion of the correction order This column also includes the findings which are in violation of the state statuafter the statement, "This Rule is not reas evidence by." Following the survey findings are the Suggested Method of Correction and Time period for Correction Endeated The FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THE WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOUNDATIONS OF MINNESOTA STATES STATUTES/RULES.	te is  "To r. ite net ors tion. GOF	
2 302	MN State Statute 144 or related disorder tra		disease	2 302			
	ALZHEIMER'S DISEA DISORDER TRAININ MN St. Statute 144.68	G:	)				
	(a) If a nursing facility Alzheimer's disease or related dis segregated or general care staff and their supervisors care.	orders, whether in I unit, the facility's	a direct				

Minnesota Department of Health

STATE FORM 8899 Z60211 If continuation sheet 2 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		00498	B. WING		05	/12/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CAPITOL	VIEW TRANSITIONAL CA	ARE CENTER	KSON STREET AUL, MN 55101			
()(1)	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	COPPECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO TO DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 302	Continued From page	2	2 302			
	related disorders; (2) assistance with ac (3) problem solving w and (4) communication sk (c) The facility shall p written or electronic for training program, the trained, the frequency topics covered.	Alzheimer's disease and ctivities of daily living; with challenging behaviors;				
	by: Based on interview at facility failed to provid designated represent training program for A related disorders, the trained, the frequency topics covered. This hall 22 residents of the Findings include:  On 5/12/16 at 9:22 a. reported the facility haresidents and/or their a description of the trailed and the facility haresidents and the facility haresidents and for their a description of the trailed and the facility haresidents and for their a description of the trailed and the facility haresidents and for their and the facility haresidents and for the facility haresidents and fa	m. the administrator ad failed to provide to designated representatives aining program for and related disorders, the ees trained, the frequency of				

Minnesota Department of Health

STATE FORM E899 Z60211 If continuation sheet 3 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _		
	00498				05/12/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CAPITOL	VIEW TRANSITIONAL C	ARE CENTER	SON STREET JL, MN 55101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 302	reviewed 7/14/15, dir Education Topics: "Al explanation of Alzheir disorders; assistance problem solving with communication skills. consumers in written description of the trai	ected staff on Annual zheimer's/Dementia: an mer's disease and related with activities of daily living' challenging behaviors; and The facility shall provide to or electronic form a ning program, the categories , the frequency of training	2 302		
	SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a process to provide to consumers in written or electronic form a description of the Alzheimer's disease and related disorders training program, the categories of employees trained, the frequency of training and the basic topics covered. The administrator or designee could educate staff involved in this process on the new procedure.  TIME PERIOD FOR CORRECTION: Twenty-one				
21426	(a) A nursing home maintain a comprehe infection control prog current tuberculosis it issued by the United Control and Preventic Tuberculosis Eliminat	provider must establish and nsive tuberculosis ram according to the most infection control guidelines States Centers for Disease on (CDC), Division of tion, as published in CDC's ty Weekly Report (MMWR).	21426		

Minnesota Department of Health

STATE FORM E899 Z60211 If continuation sheet 4 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED		
		00498		B. WING		05	/12/2016
	ROVIDER OR SUPPLIER	ARE CENTER	640 JACKS	RESS, CITY, STA SON STREET IL, MN 55101	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIEN Y MUST BE PRECEDED LSC IDENTIFYING INFO	NCIES D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21426	Continued From page infection control plan unpaid employees, or residents, and volunte Health shall provide t regarding implementation (b) Written compliant be maintained by the	that covers all pai ontractors, studen eers. The Departn echnical assistand ation of the guideli ce with this subdi	ts, nent of ce ines.	21426			
	This MN Requirement by: Based on interview a facility failed to docur tuberculosis (TB) skir for 1 of 5 residents (For Screening. The facility of Baseline TB Scree and Boarding Care Horesidents (R17, R123 addition, the facility fathe TST given for 1 of for TB screening.	nd document reviewent complete resentest (TST) that we can be a test (TST) that we can	ew, the sults of the vas given r TB completion sing Home r 5 of 5 63). In results of				
	R158 was admitted to R158's admission Mil R158's immunization given the first step TS read on 4/14/16. The The Baseline TB Screed and Boarding on the completed.	nimum Data Set (I record revealed F ST on 4/12/16 with second TST was eening Tool for Nu Care Home Resid	MDS). R158 was n results not given. Irsing ents was				

Minnesota Department of Health

STATE FORM E899 Z60211 If continuation sheet 5 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00498		B. WING		05/	12/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARITOI	VIEW TRANSITIONAL CA	ADE CENTED	640 JACKS	ON STREET			
CAPITOL	VIEW TRANSITIONAL CA	ARE CENTER	SAINT PAU	L, MN 55101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCE Y MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21426	Continued From page	÷ 5		21426			
	R17's admission MDS Screening Tool for Nu Care Home Residents	6. The Baseline TB rrsing Home and Bo s was not completed	d.				
	R123 was admitted to R123's entry MDS. The Tool for Nursing Home Residents was not co	ne Baseline TB Scree e and Boarding Car	eening				
	R153 was admitted to R153's admission MD Screening Tool for Nu Care Home Residents	S. The Baseline TB Irsing Home and Bo	arding				
	R163 was admitted to R163's immunization Screening Tool for Nu Care Home Residents	record. The Baselin Irsing Home and Bo	e TB arding				
	E1's start date was 2/ was given on 2/21/16 2/23/16. The second	, with results read o	n				
	On 5/12/16, at 10:25 at (DON) confirmed they screening for resident screening forms compared they screening forms compared they are poor further stated at TST before working. It recently it would be at TST 1st step they working should have Capitol View undated Screening Patients for	y did not do symptor is, did not have sympleted. DON also co 2nd step TST. At 11 I new staff get initial if they had 2 step TS ccepted. If they had uld do 2nd step here a 2nd step TST.  policy MI20 - Tuber	m sptom spfirmed soo a.m. 1st step ST proof of e.				
	screening Fatients to screen all patients for disease (TB) b. Any documented negative the previous 12 month (two-step) TST or (on	tuberculosis infection patient without TST, BAMT or CXF ins will receive a bas	on and R within seline				

Minnesota Department of Health

STATE FORM 6899 Z60211 If continuation sheet 6 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		o. ' '	TIPLE CONSTRUCTION		SURVEY PLETED	
		00498	B. WING		05	/12/2016
	ROVIDER OR SUPPLIER  VIEW TRANSITIONAL C	ARE CENTER	STREET ADDRESS, CITY 640 JACKSON STRE SAINT PAUL, MN 55	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI LSC IDENTIFYING INFORMATION		X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETE DATE
21426	admission g. Scree readmissions for Tubidisease will be in conregulations."  Capitol View undated Employee Screening shall be screened for and disease, using a (TST) or blood assay tuberculosis (BAMT) prior to beginning em to the first skin test is administer a second sthe first test.  SUGGESTED METH director of nursing or review/revise policies Tuberculosis screenirensure the policy was	ning of new admissions of erculosis infection and appliance with State  policy MI19 - Tuberculosis for directed "All employe tuberculosis (TB) infection two-step tuberculin skin for Mycobacterium and symptom screening, ployment a. If the reach negative, the facility will skin test 1 to 2 weeks after the control of th	sis, es on eest ion Fhe			

Minnesota Department of Health